No. 15504

In the United States Court of Appeals for the Ninth Circuit

UNITED STATES OF AMERICA, APPELLANT

v.

HELEN MCCARTHY WILLOUGHBY, APPELLEE

ON APPEAL FROM THE UNITED STATES DISTRICT COURT FOR THE SOUTHERN DISTRICT OF CALIFORNIA, NORTHERN DIVISION

BRIEF FOR APPELLANT

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INDEX

CITATIONS

Cases:

Cases—Continued

Statutes and Regulations:

Statutes and Regulations—Continued

Miscellaneous:

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BRIEF FOR APPELLANT

This action was brought by Helen McCarthy Willoughby to recover benefits, as primary beneficiary, under her deceased son's National Service Life Insurance policy (R. 3-5). The Government defended under 38 U.S.C. 802(w) on the ground that reinstatements of the policy had been procured by fraudulent misrepresentations of the insured (R. 6-11). On November 21, 1956, the district court, sitting without a jury, entered judgment for the plaintiff (R. 44-45). The United States filed a notice of appeal on January 16, 1957 (R. 45).

The jurisdiction of the district court rested upon Section 617 of the National Service Life Insurance Act (38 U.S.C. 817). This Court's jurisdiction is invoked under 28 U.S.C. 1291.

STATEMENT OF THE CASE

The undisputed facts are as follows: In September 1944, John R. Willoughby, while in military service, was issued a National Service Life Insurance policy in the amount of $10,000 (R. 38). He received a medical discharge from the service in November 1945 as suffering from diabetes mellitus (R. 39).

On October 1, 1947, Willoughby permitted his National Service Life Insurance to lapse by failing to pay the premiums due thereon (R. 40). On July 12, 1948, he applied for reinstatement of the lapsed insurance pursuant to Veterans Administration regulations (see *infra,* p. 8), which provided for reinstatement on a comparative health basis, *i.e.,* where the applicant is in as good health on the date of application as he was on the due date of the premium in default (R. 40). In filling out the prescribed Veterans Administration form (R. 19), Willoughby answered questions 8, 9 and 10 therein as follows (*ibid.*):

> 8. Are you now in as good health as you were on the due date of the first premium in default? [x] Yes [ ] No.
>
> 9. Have you been ill, or suffered or contracted any disease, injury, or infirmity, or been prevented by reason thereof from attending your usual occupation, or consulted a physician, surgeon, or other practitioner for medical advice or treatment at home, hospital, or elsewhere, in regard to your health, since lapse of this insurance? [ ] Yes [x] No. (If "yes," give all dates and full particulars below.)
>
> 10. Have you ever applied for disability compensation, retirement pay, pension or waiver of

insurance premiums? [x] Yes [ ] No. (If "yes," give Claim No. below.) C—No.

Willoughby did not list a "C-Number" in the space provided following question 10 (*ibid.*).

On the basis of the representations as to comparative health contained in this application, and upon payment of the due premiums, Willoughby's policy was reinstated by the Veterans Administration in July 1948 without requiring a medical examination (R. 29-30). Willoughby continued to pay the premiums on this policy until December 1, 1949, when the insurance again lapsed for non-payment of premiums (R. 40.)

On February 6, 1950, Willoughby executed another application for reinstatement on a comparative health basis (*ibid.*). In respect to the question, "Are you now in as good health as you were on the due date of the premium in default," Willoughby answered, "Yes." He answered "No" to the question as to whether, since the lapse of the insurance he had been ill, or had been prevented from attending his usual occupation or had consulted a physician (R. 27). This application (R. 20) did not contain a question similar to question 10 appearing on the prior application (*supra,* p. 2).

Again, on the basis of Willoughby's statements as to comparative health, the Veterans Administration, on February 9, 1950, reinstated his policy without requiring a medical examination (R. 15). Payment of premiums continued until September 1, 1950, when the policy lapsed for the third time for failure to pay premiums (R. 40).

On October 19, 1950, Willoughby once more applied for reinstatement of his insurance (*ibid.*). This application (R. 21) was identical in form to the second application, and Willoughby's answers to the questions were the same (*ibid.*). Because the application was dated August 30, 1950, and not mailed until October 19, 1950, Willoughby was informed by the Veterans Administration that it would be necessary to execute a supplemental comparative health statement covering the period from August 30, 1950 through October 19, 1950 (R. 30). Willoughby was also required to certify that "I am now in sound condition, mentally and physically, excepting as follows ——" (*ibid.*).

Without making any insertions in the space provided therefor, Willoughby executed this statement on December 1, 1950 (R. 22). Solely on the basis of the representations made by Willoughby in his application and supplemental certificate, the Veterans Administration reinstated the policy (R. 30). Willoughby continued to pay the premiums on this policy until his death in May 1952 (R. 17).

The district court expressly found that Willoughby had falsely represented the state of his health on all of his applications for reinstatement (R. 41). This finding was based in substance upon the following evidence:

Between the lapse of his insurance on October 1, 1947, and his first application for reinstatement on July 12, 1948, Willoughby visited a physician, Dr. E. R. Schottstaedt of Fresno, California, on two occasions to receive various treatments and tests with respect to his diabetic condition (R. 25). Between the lapse of his insurance on December 1, 1949, and his second application for re-

instatement on February 6, 1950, Willoughby visited another physician, Dr. C. E. Suits of Visalia, California, for examination and treatment on eight occasions (R. 27-28).[1] Dr. Suits reported that Willoughby had suffered from "diabetes for five years, swelling of ankles and feet, upset stomach, occasional nocturia and chronic diarrhea for six months" and diagnosed his condition as "diabetes, chronic diarrhea, mild hypertension" (R. 28). At the trial, Dr. Suits also testified that Willoughby's eyesight was progressively failing during the course of his treatment (*ibid.*).

When Willoughby's policy lapsed for the third time, *i.e.,* September 1, 1950, he was in the Fresno Veterans' Hospital, having been admitted some three weeks before (R. 31). His physical report showed that he had suffered almost complete loss of vision in his left eye with marked retinitis and partial loss of vision in his right eye with retinitis (*ibid.*). While in the hospital it was necessary for Willoughby to receive two blood transfusions and to have his insulin intake increased (*ibid.*). He was discharged on September 8, 1950, as having attained maximum hospital benefit with a diagnosis of "diabetes, mellitus, severe" and "glomerulus nephritis, chronic, severe, with azotemia" (*ibid.*). It was the progression of these diseases that resulted in his death in May 1952 (R. 60).

After Willoughby's death, his mother, appellee herein, who had been designated as primary beneficiary, filed a claim for the proceeds of the policy (R. 17). Her claim was denied on May 14, 1953, by the Director

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[1] December 10, 1949; December 14, 1949; December 19, 1949; December 21, 1949; December 27, 1949; December 31, 1949; January 13, 1950; January 28, 1950.

of Claims Service of the Veterans Administration's District Office at Denver, Colorado, on the ground that Willoughby had secured reinstatements of the policy by fraud in misrepresenting the state of his health in his applications for reinstatement (R. 17-18).[2]

Following denial of her appeal by the Board of Veterans' Appeals, appellee brought this action in the court below to recover the $10,000 payable under the policy (R. 3-5). The Government raised the defense of fraud (R. 8-11). At the conclusion of the trial the district court gave judgment in favor of the appellee (R. 44). Although finding expressly that the insured had knowingly made false representations with respect to material facts in his applications for reinstatement, and that the insured had made these representations with intent to deceive the Veterans Administration (R. 41), the district court stated that, under this Court's decision in *United States* v. *Kelley,* 136 F. 2d 823 it was required to find that the Government did not rely on the statements contained in the applications, since there was on file with the Veterans Administration information demonstrating the falsity of the representations (R. 36). The Court held that the Veterans Administration, as a single entity, had actual notice of the true state of health of the insured (R. 42-43).[3] This appeal followed (R. 45).

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[2] It was the opinion of the Chief Medical Consultant at the Denver District Office that if the medical evidence then on record had been disclosed when the various applications for reinstatement were made, the applications would have been medically rejected (R. 17).

[3] The Court noted that "[w]ere it not for the Kelley case, [it] would adopt the reasoning contained in the decision of the Circuit Court of Appeals of the District of Columbia in the case of *United States* v. *Kieffer* [*sic*], 228 F. 2d 448, 1956, and would uphold the defenses of fraud set forth in the answer of the government" (R. 36).

STATUTES AND REGULATIONS INVOLVED

1. The National Service Life Insurance Act of 1940, 54 Stat. 1008, as amended (38 U.S.C. 801, *et seq.*) provides in pertinent part:

§ 802. Persons insurable; * * *

* * * * *

(w) *Incontestability of policies.*

* * * * *

Subject to the provisions of section 812 of this title, all contracts or policies of insurance before or after August 1, 1946, issued, reinstated, or converted shall be incontestible from the date of issue, reinstatement, or conversion, except for fraud, nonpayment of premium, or on the ground that the applicant was not a member of the military or naval forces of the United States.

* * * * *

§ 808. *General administrative provisions.*

The Administrator, subject to the general direction of the President, shall administer, execute, and enforce the provisions of this chapter, shall have power to make such rules and regulations, not inconsistent with the provisions of this chapter, as are necessary or appropriate to carry out its purposes, and shall decide all questions arising thereunder. * * *

2. Veterans Administration Regulations 3423 and 3424 (38 C.F.R. 1949 Ed., §§ 8.23, 8.24) provide in pertinent part:

§ 8.23—*Health Requirements:* National Service Life Insurance * * * may be reinstated if application and tender of premiums are made:

(a) On or before July 31, 1948, or within three months after lapse, whichever is later, provided the applicant be in as good health on the date of application and tender of premiums as he was on the due date of the premium in default and furnishes evidence thereof satisfactory to the Administrator.

(b) Subsequent to July 31, 1948, and after expiration of the three-month period mentioned in paragraph (a) of this section, provided applicant is in good health (§ 8.1) on the date of application and tender of premiums and furnishes evidence thereof satisfactory to the Administrator of Veterans' Affairs.

§ 8.24—*Application and medical evidence:* * * * Applicant's own statement of comparative health may be accepted as proof of insurability for the purpose of reinstatement under § 8.23(a), but, whenever deemed necessary in any such case by the Administrator, report of physical examination may be required. * * *

SPECIFICATION OF ERRORS

1. The district court erred in holding that a National Service Life Insurance policy, reinstated solely on the basis of the applicant's own false statements of comparative health, cannot be contested for fraud by the Veterans Administration where its claims file contains information which would demonstrate the falsity of the representations.

2. The district court erred in holding that, in approving an application for reinstatement of insurance,

the Insurance Service of the Veterans Administration is chargeable with actual notice of facts contained in the Administration's claims file.

3. The district court erred in holding that, in reinstating the lapsed policy, the Veterans Administration did not rely upon the false statements of comparative health contained in the insured's applications for reinstatement.

4. The district court erred in granting judgment for the plaintiff.

SUMMARY OF ARGUMENT

The court below has held that the Veterans Administration, in reinstating a lapsed policy of National Service Life Insurance solely in reliance upon the applicant's own false representations of comparative health, cannot contest the policy for fraud where an examination of the applicant's disability compensation file would have demonstrated the falsity of the representations. Since there is no suggestion in this case that the employees of the Insurance Service had personal knowledge of the contents of the claims file prior to the death of the insured, the decision below imposes upon the employees of the Insurance Service of the Veterans Administration who approve applications for reinstatement a duty to search the claims files for possible medical information which would contradict the applicant's own representations as to his state of health.

As a practical matter, the personnel of the Insurance Service are entirely justified in relying upon the applicant's own representations. In order to avoid delay in processing the flood of applications which followed the Veterans Administration's campaign to inform veterans of their insurance reinstatement rights, the In-

surance Service adopted the procedure of automatically approving applications for reinstatement, provided that payments of premiums were enclosed and the applicant had not unsatisfactorily answered one of the questions on the application concerning his comparative health. This expeditious practice was followed even where the applicant indicated that he had previously filed a claim with the Veterans Administration, since it was apparent that having filed at one time a claim for "disability compensation, retirement pay, pension or waiver of insurance," did not mean that an examination of the claims file would provide information bearing on the applicant's health during the period of lapse. Indeed, the Veterans Administration, regarding this question as surplusage, changed its application form (see Willoughby's second and third applications (R. 20, 21)), and no longer asks the veteran whether he had previously filed a claim. Thus, the Insurance Service relies exclusively upon the relevant information furnished by the applicant bearing on his state of health.

Moreover, neither statute nor case law, including this Court's decision in *United States* v. *Kelley,* 136 F. 2d 823, imposes upon the Insurance Service of the Veterans Administration a duty to examine an applicant's claims file for medical information contradictory to that supplied by the applicant. 38 C.F.R. § 8.23, authorizing reinstatement of lapsed policies on the basis of comparative health, parallels a former section of the National Service Life Insurance Act. This section was repealed for the express purpose of permitting the Administrator of Veterans Affairs to prescribe by regulation the conditions of reinstatement, and the

regulation adopts the language of the section in providing that policies shall be reinstated on evidence "satisfactory to the Administrator." 38 C.F.R. § 8.24, formulating and publicizing the quantum of evidence which the Administrator deems "satisfactory", provides that the "applicant's own statement of comparative health may be accepted as proof of insurability." This regulation is clearly a valid exercise of the Administrator's authority and is plainly "necessary" and "appropriate" to carry out the purposes of the Act.

The pertinent cases recognize and endorse the right of the Veterans Administration to reinstate a lapsed policy of National Service Life Insurance solely on the basis of the applicant's own representations of comparative health. *United States* v. *Kiefer,* 228 F. 2d 448 (C.A. D.C.), certiorari denied, 350 U.S. 933; *McDaniel* v. *United States,* 196 F. 2d 291 (C.A. 5). We show below that this Court's opinion in *United States* v. *Kelley,* 136 F. 2d 823, is plainly inapposite and that certain dicta in the opinion, which the court below felt constrained to follow, has been specifically distinguished by other courts of appeals in cases involving facts similar to those here involved.

We urge finally that, even if the employees of the Veterans Administration who approved the applications here were under a duty to search for the applicant's claims file, it is settled beyond question that their failure to do so can neither bind the United States nor estop it from contesting the validity of the policy on the ground of fraud.

ARGUMENT

I

The District Court Erred in Holding That the Veterans Administration Did Not Rely Upon the False Statements of Comparative Health Contained in Willoughby's Applications for Reinstatement.

A. *Under the Established Practice of the Veterans Administration, the Insurance Service, in Processing Applications for Reinstatement, Relies Upon Applicants' Representations*

The procedures followed by the Insurance Service in connection with Willoughby's applications for reinstatement were neither unusual nor haphazard, but were in accord with established practice dictated by practical considerations. Efficient administration requires that the service of the Veterans Administration handling insurance matters, including applications for reinstatement, be separate and distinct from those services handling hospitalization, pensions, disability, compensation, loans, educational matters, vocational rehabilitation and other veterans' benefits. By separating these functions and by maintaining separate files for National Service Life Insurance for individual veterans, more expeditious processing of insurance matters is made possible. See *United States* v. *Kiefer,* 228 F. 2d 448, 451 (C.A. D.C.), certiorari denied, 350 U.S. 933.

In addition, to provide better service to the millions of veterans in all parts of the country, these functions are administered decentrally by the various services. Thus, veterans' claims files, containing their applications for disability compensation and medical histories, are maintained in Veterans Administration Regional Offices. Insurance files, on the other hand, have since

1946, been maintained in Veterans Administration District Offices.[4]

The mere fact that the insurance and compensation functions of the Veterans Administration are administered separately and decentrally does not, of course, preclude utilization of the claims files by the Insurance Service. It does, however, necessarily result in delay in the processing of applications where examination of a claims file is made. It was to minimize this delay in processing applications for reinstatement, and the concurrent hiatus in insurance protection, that the procedure followed here was adopted.

That the adoption of this procedure was reasonable in the circumstances cannot be seriously questioned. By June 30, 1947, there remained only some 5,700,000 NSLI policies of the approximately 16,000,000 policies which had been in force at the termination of hostilities two years earlier.[5] In its avuncular relationship to veterans, the Veterans Administration undertook an extensive publicity campaign to persuade veterans to reinstate their insurance. "Through June 30, 1948, the informational program produced approximately 1¾ million applications for reinstatement covering a total of over $10,000,000,000 of insurance."[6]

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[4] Thus, Willoughby's insurance records were on file in the Veterans Administration's District Office at Oakland, California, while his claims records were on file in the Regional Office at San Francisco, California (R. 33, 69).

[5] See Annual Report of the Administrator of Veterans' Affairs for the Fiscal Year Ending June 30, 1945, H. Doc. 467, 79th Cong., 2d Sess., p. 26; Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ending June 30, 1947, H. Doc. 453, 80th Cong., 2d Sess., p. 46.

[6] Annual Report of the Administrator of Veterans Affairs for the Fiscal Year Ending June 30, 1948, H. Doc. 8, 81st Cong., 1st Sess., p. 66.

The Veterans Administration had the choice between two alternatives, neither of which was completely satisfactory. On the one hand, it could delay final action upon the reinstatement applications until the claims file of each veteran was examined to make certain that the application was accurate. While this procedure would have protected the Veterans Administration against fraudulent claims such as is here involved, it would have resulted in a substantial delay in processing the reinstatement application, and, in the interim, the applicant would be without NSLI insurance. On the other hand, the Veterans Administration could generally accept the applicant's representation at face value without checking his claims file. This procedure would permit expeditious action on reinstatement applications, and while the Veterans Administration recognized that in the process it might grant reinstatement upon fraudulent applications it anticipated that these would be relatively few in number. To avoid penalizing the many in order to guard against the relatively few, and thereby better to discharge its responsibilities to veterans generally, the Veterans Administration adopted the latter procedure—a decision further buttressed by the fact that transferal of the claims files from the Regional Offices to the District Offices, located in other cities, would have resulted in similarly substantial delays in handling other claims for veterans' benefits by the Claims Service, which claims could not be processed without the claims files.

Under the procedure thus adopted, the Insurance Service does not delay reinstatement where the applicant represents (1) that he is now in as good health as he was on the due date of the first premium in default, and (2) that he has not been ill or consulted a physician

since the lapse of his insurance (R. 64). Where, however, either question is not so answered, the application is forwarded to the Insurance Medical Division for further consideration (R. 64). Even at the time of Willoughby's first application for reinstatement, where the application form asked the veteran to note his "C" number if he has "ever applied for disability compensation, retirement pay, pension or waiver of insurance premiums," this same procedure was followed. See *McDaniel* v. *United States,* 196 F. 2d 291, 294 n. 3 (C.A. 5); *United States* v. *Kiefer,* 228 F. 2d 448, 451 (C.A. D.C.), certiorari denied, 350 U.S. 933.

The reasons for this are obvious. As the embracive nature of the question indicates, claims are not limited to disability claims, and "C" numbers may be assigned, *inter alia,* to claims for retirement pay, pensions or waiver of premiums. See *United States* v. *Kiefer, supra* at 451. Thus, the fact that an application for reinstatement of insurance has a "C" number does not necessarily mean that he has any physical disability whatever. While the "C" number may have been issued for a disability claim, this possibility was not regarded as sufficient in itself to justify the delay involved in requiring examination of the applicant's claims file. For even when the "C" number was issued in connection with a disability claim, this did not mean that the claims file would contain information bearing on the applicant's current eligibility for reinstatement on a comparative health basis. The claim for disability benefits may have been made substantially prior to the lapse of insurance—as was the case in a goodly number of instances where disability claims were filed concurrently with the mass discharges from the armed services in 1945 and 1946—and the disability for which the

"C" number was issued may have been cured or may be no worse on the date of application for reinstatement than it was on the due date of the premium in default. The claim for disability benefits may also have been denied for lack of compensability. Furthermore, assuming that the applicant had a medical history subsequent to the date of lapse, that history would not necessarily be contained in the claims file since the applicant may have been treated by private physicians.

Because examination of the claims file may thus prove fruitless, the Veterans Administration sought to determine from the applicant himself whether it will be necessary to submit his application to the Medical Division for further consideration. And, as Willoughby's second and third applications for reinstatement reveal (R. 20, 21), the form no longer inquires of the veteran whether he has ever applied for "disability compensation, retirement pay, pension or waiver of premiums"; nor is the veteran asked to insert his "C" number if, in fact, he has one. Hence, if the applicant states in answer to the comparative health questions that he is now in as good health as he was on the date of lapse, and that he has not been ill or consulted a physician since that time, there is no occasion to delay approval of the application for reinstatement. To act otherwise would be to presume in every case where satisfactory answers are given to such questions, that the applicant has, *prima facie,* made false representations.

In refusing to indulge in this presumption, which experience has shown to be contrary to fact in most cases, the Veterans Administration recognized that there would be a small percentage of cases in which the

reinstatement would be based on inaccurate representations. Where the applicant has proceeded in good faith, payment on the policy is made even though the applicant was, in fact, ineligible for reinstatement. However, where the applicant knowingly submits false representations (as the court below found to be the situation here), he should not be permitted to profit from his deliberate action by a ruling that payment on his policy is also required.

B. *Reinstatement of NSLI Policies Solely on the Basis of an Applicant's Own Representations of Comparative Health Is Authorized by Valid Administrative Regulations*

As we have seen, the reinstatement of Willoughby's insurance, on the basis of his own representations of comparative health without a search for his claims file, was not the result of negligence on the part of the Insurance Service. Rather, it was in accordance with a settled administrative practice established by deliberate decision. There is nothing in the statute or regulations which suggests that this practice is unauthorized or that the Insurance Service employees who processed Willoughby's application were under any duty to examine his claims file. To the contrary, this practice was authorized by Congress and by the regulations.

During the period here involved, the Act contained no general provisions as to the terms and conditions for reinstatement.[7] Earlier, in Section 602(y) of the Act,

[7] On this score, the Act provided only that reinstatement should not be denied because of any disability or disabilities, less than total in degree, resulting from or aggravated by active service. 38 U.S.C. 802(c)(2).

Congress had made express provision as to the state of health required for reinstatement. Act of August 1, 1946, 60 Stat. 781, 787.[8] With respect to applications made within six months after the date of enactment of the Insurance Act of 1946, or within six months after the date of lapse, whichever was later, Section 602(y)(2) had provided for reinstatement where the applicant was "in as good health" on the date of application as he was on the due date of the premium in default and "furnishes evidence thereof satisfactory to the Administrator." With respect to applications subsequent to that cut-off date, Section 602(y)(1) had required the applicant to furnish "evidence satisfactory to the Administrator" that he was "in good health" on the date of application. At the request of the Administrator, and in order to permit greater administrative flexibility in fixing the terms and conditions of reinstatement, Section 602(y) was repealed shortly after its enactment and was not in force at the times

[8] "(y)(1) Any level premium term insurance which has lapsed may be reinstated within the term upon written application, payment of two monthly premiums, and evidence satisfactory to the Administrator that the applicant, subject to the provisions of the second sentence of section 602(c)(2), *supra*, is in good health.

"(2) Any level premium term insurance which has lapsed may be reinstated within the term upon written application, made within six months after the date of such lapse or within six months after the date of enactment of the Insurance Act of 1946, whichever is the later, and payment of two monthly premiums, provided such applicant is in as good health on the date of application and tender of premiums as he was on the due date of the premium in default and furnishes evidence thereof satisfactory to the Administrator: *Provided*, That when the insured makes inquiry prior to the expiration of the grace period disclosing a clear intent to continue insurance protection, an additional reasonable period not exceeding sixty days may be granted for payment of premiums due, but premiums in any such case must be paid during the lifetime of the insured."

Willoughby applied for reinstatement. Act of February 21, 1947, 61 Stat. 6. See H. Rept. 13, 80th Cong., 1st Sess.; S. Rept. 22, 80th Cong., 1st Sess.[9]

Pursuant to the authority vested in him "to make such rules and regulations, not inconsistent with the provisions of this Act, as are necessary or appropriate to carry out its purposes" (38 U.S.C. 808), the Administrator had prescribed the following regulations

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[9] Both the House and Senate Reports on the bill repealing Section 602(y) include a letter from the Administrator of Veterans Affairs which both committees referred to as explaining the need for the proposed legislation. The letter stated in pertinent part (H. Rept. 13, p. 3, S. Rept. 22, p. 3, 80th Cong., 1st Sess.):

> The purpose of section 3 of the proposed bill is to repeal subsections (y)(1) and (y)(2) of section 602 of the National Service Life Insurance Act of 1940, as amended. Subsection (y)(1) authorizes reinstatement of level-premium term insurance upon written application, payment of two monthly premiums, and evidence satisfactory to the Administrator that the applicant, subject to the provisions of the second sentence 602(c)(2), is in good health. The part of section 602(c)(2) which is referred to contains independent provisions relating to the exclusion of service-connected disability, less than total in degree, in determining good health for reinstatement purposes. These general provisions would continue to be applicable to reinstatement as provided for by regulations upon the repeal on subsection (y)(1).
>
> Reinstatement within the term, upon the payment of two monthly premiums and a showing of good health, is now authorized under Veterans' Administration regulations and to meet existing conditions, was so authorized for several years prior to the enactment of subsection (y)(1). Although no change in such regulations is presently contemplated, it is believed that the matter of reinstatement generally is so affected by changing conditions involving the interests of policyholders as a group that considerable flexibility should be permitted in determining when and upon what conditions reinstatement may be accomplished. In keeping with this general principle, the provisions of subsection (y)(1) should be repealed in order that regulations with respect to the subject matter thereof shall be susceptible of such periodic changes as may be warranted.

with respect to reinstatement: 38 C.F.R. § 8.23(a) (*supra,* p. 8) provided that insurance may be reinstated "on or before July 31, 1948, or within three months after lapse, whichever is later, provided the applicant be in as good health on the date of application and tender of premiums as he was on the due date of the premium in default and furnishes evidence thereof satisfactory to the Administrator." As to reinstatements subsequent to that period, 38 C.F.R. § 8.23(b) (*supra,* p. 8) requires that the applicant be "in good health" on the date of application and tender of premiums and furnish "evidence thereof satisfactory to the Administrator." With respect to the quantum of evidence satisfactory to the Administrator, 38 C.F.R. § 8.24 (*supra,* p. 8) provided, in pertinent part, that the "applicant's own statement of comparative health may be accepted as proof of insurability for the purpose of reinstatement under 8.23(a) * * *."

Unless "inconsistent" with the Act or not "necessary or appropriate to carry out its purposes" (38 U.S.C. 808), these regulations must be sustained. *Zazove* v. *United States,* 334 U.S. 602, 612. Since 38 C.F.R. § 8.23 simply paralleled the language of former Section 602(y)—which was repealed in order to give the Administrator greater freedom in processing applications for reinstatement (see *supra,* p. 19)—it certainly cannot be said that this regulation, in permitting reinstatement on a comparative health basis upon evidence thereof satisfactory to the Administrator, is inconsistent with Congressional intent.[10] Nor can it be

[10] The concern of Congress that veterans retain the right to reinstate lapsed NSLI policies on a comparative health basis is evidenced by the fact that on December 5, 1947, Congresswoman Rogers of Massachusetts, aware that under the existing Veterans

suggested that 38 C.F.R. § 8.24 exceeds the authority of the Administrator. If the Administrator is empowered to reinstate on evidence of comparative health satisfactory to him, it is obvious that he is authorized to determine the character and quantum of evidence which is satisfactory to him. The regulation does no more than formulate and make public that determination, *i.e.,* that an applicant's own statements of comparative health may be accepted as proof of insurability. Further, as we have seen, there can be no serious doubt that these regulations are "necessary and appropriate" to carry out the purposes of the Act. As pointed out above, pp. 12-16, these regulations are based on weighty practical considerations and represent a reasonable solution of a complex administrative problem. *United States* v. *Kiefer,* 228 F. 2d 448 (C.A.D.C.), certiorari denied, 350 U.S. 933.

Accordingly, since the regulations are valid and the procedure followed was in accordance with the regulations, the employees of the Insurance Service who processed Willoughby's applications for reinstatement were under no duty, as a matter of law, to examine

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Administration regulations the right expired at the end of that month, introduced a bill to amend the NSLI Act and extend for another year the right to reinstate on a comparative health basis "on evidence thereof satisfactory to the Administrator." H.R. 4651, 80th Cong., 1st Sess.; 93 Cong. Rec. 11116. This bill was favorably reported by the House Committee on Veterans Affairs, H. Rept. 1164, 80th Cong., 1st Sess., and passed by the House on December 15, 1947. 93 Cong. Rec. 11414. The bill was referred to the Senate Finance Committee on December 16, 1947. 93 Cong. Rec. 11431. No action was taken on the bill in the Senate, but early in 1948 the Veterans Administration amended its regulation to extend the period within which reinstatement could be had on a comparative health basis through July 31, 1948. 13 F.R. 181 (1948).

his claims file and were justified in relying upon his representations, without thereby waiving the Government's right under 38 U.S.C. 802(w) to contest the policy thereafter on the ground that the representations were fraudulent.[11]

C. *The pertinent case law does not preclude reliance upon an applicant's own representations of comparative health.*

It is clear that the Insurance Service is under no duty to search the files of other Government agencies to determine the truth or falsity of an applicant's own statements as to his health. *United States* v. *Depew,* 100 F. 2d 725 (C.A. 10); *United States* v. *Riggins,* 65 F. 2d 750 (C.A. 9). This same conclusion has been reached with respect to the files of other services of the Veterans Administration (*United States* v. *Cooper,* 200 F. 2d 954 (C.A. 6); *Clohesy* v. *United States,* 199 F. 2d 475 (C.A. 7); *Halverson* v. *United States,* 121 F. 2d 420 (C.A. 7), certiorari denied, 314 U.S. 695; *Jones* v. *United States,* 106 F. 2d 888 (C.A. 5)), and has been followed even where the applicant has listed his "C" number on his application for reinstatement. *United States* v. *Kiefer,* 228 F. 2d 448 (C.A.D.C.), certiorari denied, 350 U.S. 933; *McDaniel* v. *United States,* 196 F.2d 291 (C.A. 5).

In *McDaniel, supra,* the insured, in twice applying for reinstatement of his National Service Life Insurance, falsely answered the comparative health questions contained therein. However, he answered in the

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[11] Even assuming that the employees were under a duty to inspect the claims file, the Government was, as we shall show, *infra,* pp. 29-31, neither bound nor estopped by their non-feasance.

affirmative to the question "Have you ever applied for disability retirement pay, pension, or waiver of insurance premiums," and did, in fact, list his "C" number (*id.* at 292). The argument was made that, although the representations in the applications for reinstatement were false, there was no fraud since the true facts concerning the insured's state of health were contained in the applicant's claims file and the applicant had listed his "C" number in his application. In rejecting this argument, the Fifth Circuit held (196 F. 2d at 294):

> * * * we think it entirely clear that no amount of casuistry short of that which would make black seem white, the false true, can explain away or justify the false answers the insured deliberately gave twice in almost as few months.
>
> We think it equally plain that it cannot be justly held that an insured who has been asked clear and simple questions, upon the understanding that his answers may be accepted as true, without further inquiry, may avoid the consequences of having answered falsely by the claim, that the United States, by consulting the disability files could have found out that what he put forward as true was in fact false, and, therefore, may not complain that it was tricked into reinstating the certificate.
>
> As this court has said, "It is elementary that one who is guilty of fraud cannot urge estoppel [or waiver] against the other party to the contract for the purpose of making his fraud effective", New York Life Ins. Co. v. Odum, 5 Cir., 93 F. 2d 641, 644. Especially may he not do this here where it is not claimed that those responsible for reinstating

the certificate actually knew that the answers given were false, but only that, if they had followed up the reference in Sec. 10 to the C-number of the disability application they would have found by inquiry that there were.

The very same argument was urged upon the District of Columbia Circuit in *Kiefer, supra,* where the applicant had also falsely represented his comparative health and had also inserted his "C" number in the space provided therefor. In addition to relying on *McDaniel,* the court ruled (228 F. 2d at 450-451):

> Where no claim number is disclosed on a reinstatement application, it has been held that "knowledge of what is contained in the files of [other Veterans Administration services] is not imputable to the insurance service which passes upon application for reinstatement." We think there are considerations which justify the application of the same rule where the claim number is disclosed.
>
> First, assignment of "C" numbers is not limited to disability claims. They include, *inter alia,* claims for retirement pay, pensions or waiver of premiums. Hence a "C" file does not necessarily contain information material in determining the insured's eligibility for reinstatement on the basis of his comparative health.
>
> Second, in the interest of efficient administration of its vast operations, the Veterans Administration insurance and compensation services maintain their respective files separately. And to expedite its great volume of business, the insurance service, pursuant to regulation, reinstates insurance without requisitioning the "C" file where the insured

affirms that his health is no worse than it was at the time his insurance lapsed. Such reliance on the applicant's representations eliminates unnecessary delay caused by needless examination of claim files that may be unrelated to comparative health. Clearly the procedure under the regulation is reasonably related to efficient administration of the insurance program and is valid.

It seems clear that the *McDaniel* and *Kiefer* decisions apply with even greater force to this case since Willoughby, as we have pointed out, *supra,* p. 3, failed to add his "C" number when he affirmatively answered, in his first application for reinstatement, that he had applied for "disability compensation, retirement pay, pension or waiver of insurance premiums."

D. *This Court's decision in United States* v. *Kelley, 136 F. 2d 823, is not to the contrary*

To begin with, *Kelley* did not involve the issuance of insurance on a comparative health basis in accordance with regulations specifically promulgated to afford expeditious processing of reinstatement applications. There, the insured had applied for disability benefits in 1931. In 1932, he applied for insurance under Section 310 of the World War Veterans Act, 1924 (38 U.S.C. 512a), which required that the applicant be in good health at the time of application. He stated in response to question 13 of the application that he had never applied for "Government compensation" and answered question 25 by stating that he was then in good health. The Government contested the policy for fraud, claiming that the answers to these questions were false. The jury found, with respect to the former answer, that the

insured had no intent to deceive, and further found that the latter answer was not, in fact, false. This Court affirmed, pointing out that the insured may not have understood that the disability benefits he had applied for in 1931 were "Government compensation" within the meaning of question 13, and that there was no evidence which required a finding that he did so understand (*id.* at 825). The Court further held that the truth or falsity of the answer to question 25 was for the jury to decide (*id.* at 826).

It was thus unnecessary to resolve the issue of the Government's reliance upon the insured's representations. The Court, however, by way of dictum, stated that the evidence did not warrant a finding that the Government relied upon or was deceived by the answer to question 13 (*id.* at 825). The Court declared that the Government's knowledge was actual rather than imputed since the information that the insured had filed a claim for disability compensation was not in the files of another Government agency but in the files of the Veterans Administration itself. Continuing, the Court pointed out that, in any event, the jury could reasonably infer that the Insurance Service had knowledge of the insured's claim for compensation since the evidence showed that his "C" number had been endorsed on the application for insurance by an employee of the Veterans Administration prior to the Insurance Service's approval of his application (*id.* at 826).[12]

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[12] The Court denied the Government's motion to amend that portion of the Court's opinion stating that the Veterans Administration had notice of the filing of a claim for compensation. In a concurring opinion on the motion to amend, Chief Judge Denman rejecting the Government's contention that the Court was imposing

In this light, it is clear that the *Kelley* case—so strongly relied upon by the court below—should not have been afforded the broad sweep that it was. In the instant case, the question is whether the Insurance Service had actual knowledge of the contents of Willoughby's claims file, and whether the Insurance Service, in the light of existing regulations, was under a duty to search Willoughby's claims file for medical information contrary to that supplied by him. In *Kelley,* however, the issue was simply whether the Insurance Service had personal knowledge that the insured had filed a claim for compensation, not even whether it had personal knowledge of the contents of the claims file. And, on the evidence, it clearly appeared that the employees of the Insurance Service who processed the

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an unwarranted administrative burden on the Administration, stated (136 F.2d at 827), "One can imagine the short shrift we would give to a similar plea of the Equitable Life * * *." We think it appropriate to note that in providing relatively inexpensive insurance to servicemen, the Government has not gone into the insurance business; rather, it has entered into, in the words of Mr. Justice Holmes, "a relation of benevolence * * * at considerable cost to itself for the soldier's good." *White* v. *United States,* 270 U.S. 175 at 180. No profit is contemplated from the administration of the National Service Life Insurance Act, and gains or savings which are made are returned to the policyholders in the form of dividends. 38 U.S.C. 805. In these circumstances, the Government has been considered in a different position from that of commercial insurers. *McIndoe* v. *United States,* 194 F. 2d 602 (C.A. 9); *United States* v. *Holley,* 199 F. 2d 575 (C.A. 5); *James* v. *United States,* 185 F. 2d 115 (C.A. 4). Moreover, it is noteworthy that *Kelley* involved an insurance claim under the war risk insurance system of World War I. Since that time, the Veterans Administration has been confronted with the necesssity of administering the several millions of insurance issued to World War II servicemen under the National Service Life Insurance Act. Whatever accuracy there might have been in Judge Denman's comparison to Equitable Life, that comparison plainly has no validity in the light of this tremendously increased administrative problem.

application for insurance, in fact, knew that a claim for compensation had been filed.

The Seventh Circuit in *Clohesy* v. *United States, supra,* and the District of Columbia Circuit in *United States* v. *Kiefer, supra,* have both regarded *Kelley* as so limited. Thus in *Kiefer,* where the controlling facts were indistinguishable for all practical purposes from those of the present case (see *supra* p. 24) the Court of Appeals for the District of Columbia Circuit distinguished *Kelley* pointing out (228 F. 2d at 451):

> There the alleged falsity related to the insured's statement, on an original application for insurance, that he had never applied for "government compensation." A Veterans Administration official had endorsed Kelley's "C" number on his application prior to its approval. The jury could reasonably have inferred from this endorsement that, since the official had found the "C" number himself, he must have found it as a result of inspection of the file. On that basis, we agree with the Seventh Circuit in Clohesy v. United States that, on the particular facts of Kelley, the insurance section passing on the application had "actual, not imputed" knowledge that the insured had filed for compensation.[13]

Thus, since the *Kelley* decision, two courts of appeals have regarded the *Kelley* case to be limited in scope and not to reach a situation such as is here presented.[14] And none of the cases, before or after *Kelley,* afford

[13] Kiefer's petition for certiorari, based primarily upon an alleged conflict with *Kelley* and *Clohesy,* was denied by the Supreme Court. 350 U.S. 933.

[14] See also *Clarke* v. *United States,* 102 F. Supp. 338 (E.D. Mo.).

any support for the proposition that, in the circumstances of a case such as this, the employees of the Insurance Service who approved Willoughby's applications for reinstatement were not justified in accepting his representations at face value but rather were under a duty to search the files of other services of the Veterans Administration.

II

Even if the Employees of the Veterans Administration Who Approved Willoughby's Applications for Reinstatement Were Under a Duty to Examine His Compensation File, the United States Is Neither Bound Nor Estopped by Their Failure to Do So.

As we have shown, both the applicable regulations and the pertinent case law demonstrate that the Insurance Service employees who processed Willoughby's applications for reinstatement of his insurance were under no duty to consider his disability compensation file in connection therewith. However, even if it be held that they did have such a duty, we submit that their failure to examine the claims file can neither bind the United States nor estop it from contesting the policy for fraud.

It has long been the settled rule that the United States is neither bound nor estopped by the unauthorized acts of its agents. *E.g., Federal Crop Ins. Corp.* v. *Merrill,* 332 U.S. 380, 384; *United States* v. *California,* 332 U.S. 19, 39-40; *Royal Indemnity Co.* v. *United States,* 313 U.S. 289, 294; *United States* v. *Stewart,* 311 U.S. 60, 70; *United States* v. *City and County of San Francisco,* 310 U.S. 16, 32; *Wilber National Bank* v. *United States,* 294 U.S. 120, 123-124. This rule is applicable to the insurance activities of the

Government, in general (*Federal Crop Ins. Corp.* v. *Merrill, supra*), and to National Service Life Insurance, in particular. *E.g., McDaniel* v. *United States,* 196 F. 2d 291 (C.A. 5); *United States* v. *Lewis,* 202 F. 2d 102 (C.A. 5); *United States* v. *Holley,* 199 F. 2d 575 (C.A. 5); *McIndoe* v. *United States,* 194 F. 2d 602 (C.A. 9); *James* v. *United States,* 185 F. 2d 115 (C.A. 4); *United States* v. *Fitch,* 185 F. 2d 471 (C.A. 10); *Niewiadomski* v. *United States,* 159 F. 2d 683 (C.A. 6), certiorari denied, 331 U.S. 850; *Halverson* v. *United States,* 121 F. 2d 420 (C.A. 7), certiorari denied, 314 U.S. 695; *Wilber National Bank* v. *United States,* 69 F. 2d 526 (C.A. 2), affirmed, 294 U.S. 120.

Finally, it should be observed that, in any event, there is no occasion here for waiver or estoppel. The doctrine of waiver and estoppel are applicable only where the insured is deceived or misled to his detriment (*Wilbur National Bank* v. *United States,* 294 U.S. at 124), and the party who is guilty of fraud cannot urge those doctrines against the other party to the contract for the purpose of making his fraud effective. *McDaniel* v. *United States, supra,* at 294. In the present case, the district court expressly found that Willoughby deliberately made false representations to the Veterans Administration in the expectation that they would be relied upon. Accordingly, he had no adequate reason to suppose that his fraud had been effective to create a valid and binding insurance policy. As the Seventh Circuit aptly noted in *Clohesy* v. *United States, supra,* at 478:

> If, as plaintiff contends, the insured was misled by the fact that the Veterans Administration continued to accept premiums on the policy to the time

of his death, he could have been misled only into thinking that, up to that time, his conscious, deliberate deception had succeeded.

CONCLUSION

For the foregoing reasons, it is respectfully submitted that the judgment below should be reversed.

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